

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 04/13/01 and 05/09/01.
- b. The request was received on 05/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFAs-1500
 - c. EOBs
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60
 - b. HCFAs-1500
 - c. EOBs
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (4), the Division forwarded a copy of a letter requesting additional information to the carrier on 09/04/02. The respondent's 14 day response is not found in the case file. It's initial response is reflected in Exhibit II.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/07/02:
"In summary, we strongly feel and believe that we should be reimbursed an additional \$504.00 plus interest...and the EOBs enclosed clearly reflect what other insurance carriers are paying as 'fair and reasonable'."
2. Respondent: No 14 day response found

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 05/09/01. Per Rule 133.307 (d) (1) date of service 04/13/01 is out of jurisdiction which is not within the one year timeframe since the dispute was filed 05/09/02.
2. Per the provider's TWCC 60, the amount billed was \$125.00 for dos 05/09/01; the amount paid was \$0.00; the amount in dispute is \$58.00.
3. The carrier denied the billed service by code, "N – NOT APPROPRIATELY DOCUMENTED."
4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
05/09/01	E1399	\$125.00	\$0.00	N	\$58.00	MFG DMEGR (XI), (IV); (IX) (C)	The provider mentioned in the request letter that there is a MAR of \$58.00 for the CPM soft goods. The provider billed with the miscellaneous HCPCS code E1399. There is a "D" code, D0541 code that indicates CPM soft goods are reimbursed at \$58.00. When using the HCPCS code E1399, "a description of the unlisted equipment /supply is required." as is "a statement of medical necessity" which "shall include 1. claimant's diagnosis; 2. prognosis; and 3. the expected duration the equipment or supplies will be required." The provider failed to submit a description of the equipment billed for the HCPCS code E1399. The letter of medical necessity fails to include the claimant's diagnosis and the claimant's prognosis. No reimbursement is recommended.
Totals		\$125.00	\$0.00				The Requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 17th day of September 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

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